**U.S. Department of Labor**

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**Issue Date: 27 December 2006`**

Case No.: 2005-BLA-05899

In the Matter of

**A.B.**
Claimant

v.

**BLEDSOE COAL CORPORATION**
Employer

and

**JAMES RIVER COAL COMPANY**
Carrier

and

**DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS**
Party-in-Interest

Appearances: EDMOND COLLETT, Esq. — For the Claimant
LOIS A. KITTS, Esq. — For the Employer/Carrier

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

## DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On May 18, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, on May 18, 2006, the case was assigned to me. The hearing was held before me in Harlan, Kentucky on August 22, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.[1]

## I. ISSUES

The following issues are presented for adjudication:[2]

(1) whether this Claim was timely filed;
(2) whether the Claimant suffers from pneumoconiosis;
(3) whether his pneumoconiosis, if any, arose from coal mine employment;
(4) whether the Claimant is totally disabled; and
(5) whether the Claimant's total disability, if any, is due to pneumoconiosis.

## II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on October 22, 2001 (DX 2).[3] On March 4, 2003, the District Director issued a proposed Decision and Order denying benefits, based on a determination that the Claimant had established none of the elements of entitlement (DX 22). See § 718.204. The Claimant requested a formal hearing, and on July 3, 2003, the matter was forwarded to the Office of Administrative Law Judges (DX 27).

On June 8, 2004, Administrative Law Judge (ALJ) Joseph E. Kane, to whom this matter had been assigned, remanded the Claimant's case back to the District Director for a complete pulmonary evaluation, as required by § 718.406 (DX 28). In his remand order, ALJ Kane found that the report Dr. Valentino Simpao submitted regarding his pulmonary evaluation of the Claimant was "facially defective" (DX 28 at 29). ALJ Kane noted that Dr. Simpao diagnosed the Claimant with coal workers' pneumoconiosis based on X-ray findings and coal mine employment history, and also found an occupational lung disease based on an abnormal X-ray and physical findings, but ALJ Kane also found that Dr. Simpao did not address cigarette smoking as a possible cause of physical symptoms. After ALJ Kane's remand, the District Director contacted Dr. Simpao by letter (DX 28 at 4-5); Dr. Simpao provided a written response in which he stated that the Claimant had both clinical and legal pneumoconiosis, and cited reasons for his conclusions (DX 28 at 2). The Claimant's case was returned to the Office of

[1] The parties waived the opportunity to submit post-hearing briefs. See § 725.455(d).
[2] The parties stipulated that the Claimant had 10 years of coal mine employment. I find that the record supports this stipulation.
[3] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the August 22, 2006 hearing.

Administrative Law Judges for hearing in May 2005, and subsequently was assigned to me (DX 29).

## III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

### A. Factual Background

The Claimant was born in 1962. He is married and has two dependent children.[4] According to his claim, he began working for various coal mine operators in 1981 and worked as a miner between 1981 and 1983, and then again between 1989 and 1997 (DX 3). In his claim, the Claimant stated that his last mining job, from 1994 to 1997, was as a "miner man" and that he cut coal (DX 4). According to records maintained by the Social Security Administration, the Claimant's coal mine employment ran from 1982 to 1984, and then again from 1990 to 1997. The Claimant was employed by the Employer from 1995 to 1997 (DX 6).[5]

### B. Claimant's Testimony

The Claimant testified under oath at the hearing. He stated that all of his coal mine employment was in underground mines. He testified that he has been a smoker for approximately 20 years, and that he currently smokes about five cigarettes a day, or a pack a week. The Claimant testified that he last worked as a miner in 1997. He quit that employment because he had a back injury, for which he applied, and currently receives, Social Security disability payments (T. at 16-17).

The Claimant also testified that he started to have trouble with his breathing about the time he left the mines, and that this problem has worsened over the years. He is currently under the treatment of Dr. Baker for his breathing problems, and Dr. Baker has prescribed inhalers for him. The Claimant stated that he has shortness of breath when he walks. Also, he has congestion and coughing every night, which interfere with his sleep. He stated that he is unable to walk 100 yards on a level surface without stopping to rest, and that being around dust, fumes and smoke cause him difficulty with his breathing. Based on his breathing problems, he believes he would be unable to return to work in underground mining (T. at 17-20). In response to my question, the Claimant testified that, had it not been for his back injury, he believed his breathing would have permitted him to continue in the mines for a period of time (T. at 24).

The Claimant also testified by deposition, in February 2002 (DX 15). In his deposition testimony, the Claimant stated that he worked for the Employer and its predecessor company full time, six or seven days a week, from 1994 to 1997, which is when he sustained his back injury. At the time of his injury, he was running the front bridge, which involves running a piece of equipment; it is not a physically demanding job. Prior to that, he was operating a continuous

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[4] One of the Claimant's children was born in 1988 and is a college student; she qualifies as a dependent under § 725.209. See T. at 23.

[5] At the hearing, the Employer withdrew its controversion of the Responsible Operator issue (T. at 13).

miner. The Claimant summarized his work for various coal mine operators, and testified that all of his coal mine employment was underground (DX 15 at 5-9).

The Claimant testified that, at the time of his deposition, he was having back problems and breathing problems. He stated that he has shortness of breath and coughs a lot, and has been prescribed inhalers for his breathing problems. At the time of his deposition, Dr. Cornett was his physician, but he was being treated by other physicians for his back problems. The Claimant testified that he smoked about a pack of cigarettes a month, and has never smoked more than that (DX 15 at 10-13).

The Claimant verified that he was receiving social security disability payments, and stated that these payments were based solely on his back injury, and not on his breathing problems. Regarding black lung, the Claimant testified that shortly after his injury, in 1997 or 1998, he was told he was "past first stage" of black lung, but he has never been told by a physician that he was disabled due to his lung condition (DX 15 at 13-14).

C. Timeliness of Claimant's Claim

A claim for benefits must be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner. § 725.308(a). There is a rebuttable presumption that every claim for benefits is timely filed. § 725.308(c). In this case, the Employer has controverted the timeliness of the Claimant's filing of his claim (DX 29; T. at 12-13).

Although the Claimant testified by deposition that he was informed, in 1997 or 1998, that he had "black lung," the Claimant specifically stated that he was not informed that this constituted a disability. There is no evidence of record that a medical professional has ever told the Claimant that he was totally disabled due to his pulmonary condition. I find that there is insufficient evidence to overcome the presumption of timeliness. Therefore, I find that the Claimant's claim is timely filed.

D. Relevant Medical Evidence

The Claimant presented, in his affirmative case, a medical report by Dr. Glen Baker, the Claimant's treating physician, dated October 2002 (DX 18). Included in Dr. Baker's report is the interpretation of an X-ray taken in September 2002, as well as the results of pulmonary function and arterial blood gas tests Dr. Baker administered.

The Employer presented, in its affirmative case, medical reports from Dr. Bruce Broudy, dated July 2006 (EX 3 and 5) and from Dr. Lawrence Repsher, dated April 2004 (EX 1).[6] These medical reports included X-ray interpretations, pulmonary function studies, and arterial blood gas tests that these physicians completed in conjunction with their evaluations of the Claimant. The Employer also presented addendums to these reports, which Dr. Broudy and Dr. Repsher

[6] Dr. Broudy's report reflects his February 2002 examination of the Claimant.

completed in July 2006 (EX 4 and EX 2, respectively), and the transcript of a deposition of Dr. Broudy, conducted in December 2002 (EX 6).

To rebut the X-ray interpretation by Dr. Baker that the Claimant presented in his affirmative case, the Employer presented an X-ray interpretation by Dr. Jerome Wiot of the same X-ray (EX 9). To rebut the X-ray interpretation that Dr. Simpao made in conjunction with the Claimant's pulmonary evaluation under § 725.406, the Employer presented an X-ray interpretation by Dr. Wiot of that same X-ray (DX 21). To rebut the pulmonary function test results and arterial blood gas test results that Dr. Simpao conducted, as well as those presented by the Claimant in his affirmative case, the Employer submitted written interpretations by Dr. Matthew Vuskovich (EX 7 and 8).

These items will be discussed in greater detail below.

E. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[7]
(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

| Date of X-Ray | Date Read | Ex.No. | Physician | Radiological Credentials[8] | Interpretation |
|---|---|---|---|---|---|
| 11/06/2001 | 11/06/2001 | DX 7 | Simpao | None | ILO: 1/0 (3 zones) |
| 11/06/2001 | 11/18/2002 | DX 21 | Wiot | BCR, B reader | Negative |
| 02/20/2002 | 02/20/2002 | EX 5 | Broudy | B reader | ILO: 0/1 (4 zones) |
| 09/14/2002 | 09/14/2002 | DX 18 | Baker | B reader | ILO: 1/0 (3 zones) |
| 09/14/2002 | 03/18/2004 | EX 9 | Wiot | BCR, B reader | Negative |
| 03/10/2004 | 03/10/2004 | EX 1 | Repsher | B reader | Negative for pneumoconiosis: numerous mediastinal nodes: "probable healed TB" |

[7] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[8] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

Discussion

In this matter only two physicians, Dr. Simpao and Dr. Baker, have interpreted the Claimant's X-rays as showing evidence of pneumoconiosis. Dr. Simpao interpreted the Claimant's X-ray of 11/06/2001, and Dr. Baker interpreted the Claimant's X-ray of 09/14/2002; both found opacities in profusion 1/0, in multiple lung zones. The record reflects that Dr. Simpao has no specialized radiological credentials at all. Dr. Baker is a B reader, but is not Board-certified in radiology. The record also reflects that Dr. Wiot, who is Board-certified in radiology and is a B reader, examined the X-rays that Dr. Simpao and Dr. Baker interpreted, and he read both of them as negative. Based on the fact that Dr. Wiot has superior radiological credentials, I give greater weight to Dr. Wiot's interpretations than I do to the interpretations of Dr. Simpao and Dr. Baker.

The record also includes two other X-rays of the Claimant, one taken and read by Dr. Broudy on 02/20/2002, and the other taken and read by Dr. Repsher on 03/10/2004. Both of these physicians are B readers, but neither of them is a Board-certified radiologist. In each instance, the physician noted opacities in the film, but determined that the film was negative for pneumoconiosis. In Dr. Broudy's case, he determined that the opacities were insufficient in number for the film to be classified as positive. Dr. Repsher noted abnormalities that he concluded were inconsistent with pneumoconiosis.

Because the record does not contain an interpretation of either of these films by a Board-certified radiologist, I give less weight to these interpretations than I do to the interpretations of the other X-rays by Dr. Wiot. I note that the X-ray Dr. Broudy interpreted was taken several months after the 11/06/2001 X-ray and several months before the 09/14/2002 film. His interpretation is not entirely consistent with Dr. Wiot's interpretation of the other films, which Dr. Wiot found to be wholly negative; however, both came to the same conclusion: that the films are negative for pneumoconiosis. The most recent X-ray in the record is the X-ray Dr. Repsher interpreted, taken on 03/10/2004. Dr. Repsher interpreted the film as negative for pneumoconiosis, but did note abnormalities in the film.

In sum, the only chest X-ray interpretations that were positive for pneumoconiosis were made by physicians who were less qualified than a physician who interpreted the same films as negative for pneumoconiosis. In addition, a film taken later in time was also interpreted as negative for pneumoconiosis, albeit by a physician who was not a Board-certified radiologist.

Based on the foregoing, therefore, I find that the Claimant is unable to establish that he has pneumoconiosis, based on X-ray evidence.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

As stated above, the definition in § 718.204(a) of pneumoconiosis includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis, which are defined, respectively, in § 718.202(a)(1) and (2). Under these definitions, legal pneumoconiosis includes any chronic lung disease or its sequelae arising out of coal mine employment. This includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease, when causally related to coal mine employment. Consequently, a medical opinion may be expected to discuss either "clinical" pneumoconiosis, or "legal" pneumoconiosis, or both.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following physician opinions.

Dr. Valentino Simpao (DX 7, 28; CX 1)

In November 2001, Dr. Simpao administered a pulmonary evaluation of the Claimant in conjunction with this claim, as required under § 725.406. The record reflects that Dr. Simpao is Board-certified in internal medicine with a subspecialty in pulmonary disease.[9] Dr. Simpao conducted a physical examination, took a medical and work history, and administered various medical tests, including a chest X-ray, pulmonary function study, and arterial blood gas tests. He then issued a written report (DX 7).

Dr. Simpao's report reflects that the Claimant had a total coal mine employment history of 11 years, that he has smoked cigarettes since 1978, and that he currently smoked 1 pack weekly. It also reflects that the Claimant reported coughing up thick phlegm every day (for the last 10 years); wheezing at rest and on exertion, "worse when working in mines" (for the last 20 years); dyspnea while in the mines (last 18 years); productive cough (last 10 years); 10 years ago, chest pain in the morning with coughing 2-3 times a day; and onset 10 years ago of nighttime dyspnea. Dr. Simpao's report also reflected that the Claimant had a back injury in 1997 and had been hospitalized three times for back problems. He was taking several medications, including Lortab, Atrovent, and Albuterol (DX 7).

Dr. Simpao's physical examination of the Claimant noted increased resonance in the upper chest and axillary areas; a few crepitations; and slightly cyanotic nails. The Claimant walked 150 feet before complaining of shortness of breath, and climbed six steps before complaining of shortness of breath. Dr. Simpao noted the Claimant's medical test results as follows: chest X-ray – coal workers' pneumoconiosis category 1/0; vent study – normal spirometry; arterial blood gas – normal; EKG – right bundle branch block (DX 7).

Based on the test results, Dr. Simpao diagnosed the Claimant with "CWP 1/0." Regarding the etiology of this condition, Dr. Simpao wrote: "Multiple years of coal dust exposure is medically significant in his pulmonary impairment." He also wrote that the Claimant had a "mild impairment," but did not specify the nature of any impairment. Dr. Simpao's report also stated, in response to a pre-printed question, that the Claimant had an occupational lung disease caused by his coal mine employment. He commented that the basis of this diagnosis was "findings on the chest X-ray along with physical findings and symptomology."

As mentioned above, after ALJ Kane remanded this matter, the District Director contacted Dr. Simpao by letter. The District Director's letter, dated January 2005, informed Dr. Simpao that the District Director found eight years of coal mine employment, not the 11 that the

[9] Dr. Simpao's curriculum vitae does not list Board certifications. The Claimant submitted an additional document reflecting that Dr. Simpao held these certifications. See CX 1 for the Claimant's submission of Dr. Simpao's professional qualifications.
However, I could not verify Dr. Simpao's professional credentials on the American Board of Internal Medicine or American Board of Medical Specialties websites. See http://www.abim.org/who/index.shtm and http://www.abms.org/.

Claimant asserted to Dr. Simpao. Also, the District Director provided Dr. Simpao with the definitions of clinical and legal pneumoconiosis, pointed out that Dr. Simpao had not addressed cigarette smoking as a possible etiology and requested that Dr. Simpao "provide a reasoned medical opinion stating if the miner has a chronic lung disease." If yes, please advise whether your diagnosis represents clinical pneumoconiosis and/or legal pneumoconiosis. Please elaborate as to the basis for each diagnosis. For each respiratory diagnosis, please state whether the condition has been "significantly contributed to, or substantially aggravated by, dust exposure in coal mine employment" (DX 28 at 4-5).

Dr. Simpao responded promptly to the District Director's letter. In its entirety, his response is as follows:

> "I have reviewed [the Claimant's] examination performed on November 6th, 2001. I do feel that he does have clinical pneumoconiosis and legal pneumoconiosis as evidenced by his physical findings and symptomology. The miners (sic) primary cause is his multiple years of coal dust exposure, however, the miner does have a significant smoking history. It is not possible to determine the degree of (sic) these factors have influenced his pulmonary disease. The physical examination and symptomology reveals that the miner wheezes and has been doing so the past 20 years; has a productive cough for the last 10 years; has dyspnea during the last 18 years. Auscultation of lungs revealed few crepitation. He was also limited on his functional ability to walking before complaints of shortness of breath at 150 feet and limited to climbing 6 steps. In closing, [the Claimant] does have a mild impairment. His years of coal mining were all underground working at the face as a continuous miner operator and his pulmonary impairment was significantly aggravated due to this. All of the above factors have affected his ability to do (sic) perform his last coal mining job."

Dr. Glen Baker (DX 18)

The Claimant submitted a medical report dated September 2002 from Dr. Glen Baker, his treating physician.[10] Dr. Baker, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, evaluated the Claimant "for possible dust induced lung disease secondary to his coal mine employment." Dr. Baker administered a physical examination, took a medical and work history, and conducted various tests, including a chest X-ray, pulmonary function test, and arterial blood gas test. His report reflects that he considered that the Claimant had 12 years of underground coal mine employment, ending in 1997, and that he has smoked 20-25 years at the rate of a pack per week.

According to Dr. Baker's report, the Claimant reported that he had respiratory problems for 6-7 years with daily symptoms of cough and sputum production. He had occasional trouble at night, but not on a regular basis. His breathing was aggravated by exertion as well as by

[10] The Claimant testified at the hearing that Dr. Baker was his current physician (T. at 18). However, Dr. Baker's report does not contain any information regarding his treatment of the Claimant, and states that he saw the Claimant twice previously, in September 1994 and August 1998. No details of treatment on those dates are provided; however, Dr. Baker's report indicated that the September 1994 visit was for "X-ray and spirometry only" (DX 18).

various dusts. The record reflects that the Claimant was taking Combivent by inhaler for pulmonary problems.

Dr. Baker's physical examination revealed "inspiratory and expiratory wheezes." Dr. Baker noted that the Claimant walked very slowly and had a recent scar from back surgery six weeks before. Medical test results included an X-ray interpretation of coal workers' pneumoconiosis at profusion 1/0; pulmonary function tests within normal limits; normal resting arterial hypoxia.

Dr. Baker made the following diagnoses: coal workers' pneumoconiosis, category 1/0, based on abnormal X-ray and significant history of coal dust exposure; mild resting arterial hypoxemia, based on arterial blood gas analysis; chronic bronchitis, based on history. He opined that the Claimant's condition was the result of occupational coal dust exposure, commenting that "Patient has X-ray evidence of pneumoconiosis and 12 years of underground exposure at the face of the mines. He has no other condition to account for these X-ray changes." Dr. Baker also opined that the Claimant's impairment was related to occupational coal dust exposure, commenting as follows: "Patient has a 12 year history of dust exposure and X-ray evidence of pneumoconiosis. He does have 20-25 year history of smoking but only one pack per week. It is thought that any pulmonary impairment would be caused at least in part, if not significantly so, by his coal dust exposure and presence of pneumoconiosis."

Dr. Lawrence Repsher (EX 1, 2, 10)

At the request of the Employer, Dr. Repsher, who is Board-certified in internal medicine, pulmonary medicine, and critical care and is a B reader, conducted an evaluation of the Claimant in March 2004. He submitted a written report the following month (EX 1). Dr. Repsher's evaluation included examining the Claimant, taking a work and medical history, and administering various medical tests, including a chest X-ray, pulmonary function test, and arterial blood gas test. Dr. Repsher's written report presumed that the Claimant had a history of 12 years coal mine employment, all underground, the last few months of which were operating a front bridge, but for seven years prior to that, he operated a continuous miner. It also presumed that the Claimant smoked a few cigarettes a day, for about one pack per week, since age 15 or 16. Dr. Repsher noted that the Claimant was injured in 1997, has not been involved in coal mine employment since that time, and had at least two surgeries for his back. Medications listed included Lortab, Zantac, albuterol/Combivent, Advair.

Dr. Repsher's physical examination noted normal breath sounds, and no rales, rhonchi, or wheezes. Laboratory tests, according to Dr. Repsher, showed no evidence of pneumoconiosis on X-ray, although Dr. Repsher noted "evidence of calcified right hilar and right inferior mediastinal lymph nodes, probable (sic) representing a Ghone complex." Pulmonary function tests were within normal limits, including a normal diffusing capacity, which – according to Dr. Repsher – would rule out any significant interstitial lung disease, such as coal workers' pneumoconiosis. Arterial blood gases showed mild hypoxemia, but well in excess of the Department of Labor standard for presumed disability. No carboxyhemoglobin was obtained, but the nondetected serum nicotine and cotinine levels indicated that the Claimant had not smoked within the last 72 hours.

Dr. Repsher's opinion was that the Claimant did not and has not ever suffered from coal workers' pneumoconiosis or any other pulmonary or respiratory condition, either caused by or aggravated by his coal mine employment. The reasons Dr. Repsher gave for his conclusion are as follows: no chest X-ray evidence of coal workers' pneumoconiosis; no pulmonary function test evidence of coal workers' pneumoconiosis; as all test results are normal; no arterial blood gas evidence of coal workers' pneumoconiosis – mild and clinically insignificant arterial hypoxemia is most likely due to cigarette smoking. Dr. Repsher also commented that the Claimant was suffering from a number of other potentially serious medical conditions, but these were not due to his work as a coal miner, as they are diseases of the general population, primarily related to hereditary and lifestyle factors (EX 1).[11]

The Employer also submitted an addendum from Dr. Repsher, dated July 2006, written after Dr. Repsher reviewed other materials relating to the Claimant, including Dr. Baker's and Dr. Simpao's reports and Dr. Simpao's supplemental statement to the District Director (EX 2). Dr. Repsher's addendum is admissible under § 725.414(a)(3)(ii). In his addendum, Dr. Repsher states that it is his opinion that the Claimant "is not now and never has suffered from either medical or legal coal workers (sic) pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment with [the Employer] with the inhalation of coal mine dust." Dr. Repsher cited the following reasons: no chest X-ray, histologic, pulmonary function test, or arterial blood gas test evidence of coal workers' pneumoconiosis; no pulmonary impairment, with pulmonary function tests within normal limits and arterial blood gas tests showing a mild nonqualifying hypoxemia. Dr. Repsher stated that the Claimant did have a number of other serious and potentially serious diseases and conditions, unrelated to work as a coal miner, but did not specify what these were (EX 2).

Dr. Bruce Broudy (EX 3, 4, 5, 6)

At the request of the Employer, Dr. Broudy, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, conducted an evaluation of the Claimant in February 2002 and submitted a written report.[12] Dr. Broudy's evaluation consisted of a physical examination, a medical and work history, and various medical tests, including a chest X-ray, chest CT scan, pulmonary function study, and arterial blood gas test (EX 3, 5).[13]

Dr. Broudy's report presumed that the Claimant has about 14 years of coal mine employment, only 11 or 12 of which were recorded, ending in 1997, when the Claimant sustained his back injury; it also reflects that the Claimant worked "shooting from solid and on a continuous miner." This report also stated that the Claimant has been a smoker since age 20, but never had smoked more than a pack of cigarettes a month. By way of history, the Claimant reported to Dr. Broudy that he started inhaler therapy shortly after his back injury; that he has

[11] Dr. Repsher's medical report mentions borderline hypertension, chronic low back pain, and obesity, among other things.

[12] Dr. Broudy's report is dated July 2006. The reason for his delay in submitting the report is not evident in the record. An earlier version of this report is an appendix to Dr. Broudy's deposition testimony (at EX 6).

[13] Records of the medical tests that Dr. Broudy conducted are at EX 5.

trouble sleeping because of back pain and shortness of breath; has had chronic cough and sputum with daily phlegm for about 4 or 5 years; and may have had pneumonia in the past. Dr. Broudy also noted that the Claimant reported anterior chest pain with coughing, and dyspnea on exertion walking short distances, but the Claimant stated he had been out of shape since the back injury.

Dr. Broudy's physical examination was essentially normal; he noted normal respirations, clear lungs, and no cyanosis, clubbing, or edema of the extremities. The Claimant's medical tests showed some abnormalities; Dr. Broudy remarked that a reduction in the MVV in the pulmonary function test was probably effort-related, and that the resting hypoxemia in the arterial blood gas test was mild. On the chest X-ray, Dr. Broudy noted a slight increase in interstitial opacities in the mid and lower zones, which he characterized as profusion 0/1. According to Dr. Broudy, the CT scan showed similar small irregular opacities. Dr. Broudy diagnosed the Claimant with back pain, history of gastroesophageal reflux, and dyspnea. He concluded that he did not believe the Claimant to have coal workers' pneumoconiosis, and opined that the Claimant retained the respiratory capacity to work as a coal miner. Dr. Broudy also opined that the results of the spirometry and blood gases suggest that the Claimant's dyspnea is non-pulmonary in origin. Similarly, Dr. Broudy did not believe that the Claimant had any significant pulmonary disease or respiratory impairment that arose from coal mine employment; also, there is no evidence that the Claimant had chronic obstructive airways disease.

In July 2006, Dr. Broudy also submitted an addendum to his written report, which reflected that he had reviewed Dr. Simpao's initial report and Dr. Baker's report. In his addendum, Dr. Broudy observed that the test results confirm that the Claimant "has no significant ventilatory or respiratory impairment and would retain the respiratory capacity to perform the work of an underground coal miner or do similarly arduous manual labor" (EX 4).[14]

In December 2002, Dr. Broudy testified by deposition. He testified that he had evaluated the Claimant in February 2002, and had previously evaluated the Claimant in 1998. Dr. Broudy's testimony essentially duplicated his written report. Dr. Broudy confirmed that his physical examination of the Claimant was basically normal, and that he did not hear any rales, rhonchi, or wheezing, nor did he observe any cyanosis, clubbing, or edema of the extremities. Dr. Broudy testified that the mild resting arterial hypoxemia that he observed, through arterial blood gas testing, did not cause any impairment. He reiterated his diagnoses of back pain, gastroesophageal reflux, and dyspnea. Dr. Broudy testified that an individual with a normal spirogram has no impairment of his "bellows function" of the lungs, and with blood gas levels that are nearly normal, one would not expect hypoxemia to be the cause of dyspnea either. Therefore, Dr. Broudy concluded, the symptoms are probably non-pulmonary in origin, especially since there was no other evidence of pulmonary disease. In response to a question regarding the Claimant's weight of 292 pounds at a height of 72 ½ inches, Dr. Broudy commented that excessive weight can be a cause of dyspnea (EX 6 at 7-15).[15]

[14] Dr. Broudy also noted that he did not review the X-ray films that the other physicians had read as 1/0 (meaning positive for pneumoconiosis).

[15] Dr. Broudy's written report, however, reflected that the Claimant weighed 219 pounds (EX 3).

In addition, Dr. Broudy testified that the Claimant did not have any impairment caused by coal workers' pneumoconiosis and also had no pulmonary impairment attributable inhalation of coal mine dust. He concluded that the Claimant retained the respiratory capacity to perform his usual coal mine work (EX 6 at 17-18). On cross examination, Dr. Broudy conceded that he found some indication of nodulaton on the Claimant's lungs, but it was insufficient to characterize as coal workers' pneumoconiosis. He also stated that he was unable to determine the source of the Claimant's mild hypoxemia, but affirmed that coal workers' pneumoconiosis can be a causative factor in hypoxemia. However, Dr. Broudy based his conclusion on the fact that he did not diagnose the Claimant as having the disease (EX 6 at 18-20). On re-direct examination, Dr. Broudy testified that slight hypoxemia can occur in smokers, and that the Claimant's carboxyhemoglobin level was 1.8%, which may be indicative of continued exposure to smoke, but also is on the high end of normal (EX 6 at 20-21).

Dr. Matthew Vuskovich (EX 7, 8, 11)

At the request of the Employer, Dr. Vuskovich, who is Board-certified in occupational medicine and is a B reader, evaluated the validity of the pulmonary function and arterial blood gas tests administered to the Claimant by Dr. Simpao (EX 8) and Dr. Baker (EX 7), and submitted written reports, dated April 2004. These reports are admissible under § 725.414(a)(3)(ii).

Dr. Vuskovich concluded that both sets of pulmonary function tests were valid, and they evidenced neither obstructive nor restrictive pulmonary impairment. Similarly, Dr. Vuskovich concluded that both sets of arterial blood gas tests reflected normal function. Although Dr. Baker concluded, based on arterial blood gas test results, that the Claimant had a mild hypoxemia, because the Claimant's $PO_2$ value exceeded 60, Dr. Vuskovich concluded that his pulmonary function was not significantly impaired.

Discussion[16]

Dr. Simpao and Dr. Baker opined that the Claimant has both clinical and legal pneumoconiosis. Dr. Repsher and Dr. Broudy, on the other hand, concluded that the Claimant has neither clinical nor legal pneumoconiosis. As noted above, Dr. Simpao stated that his conclusions were based on X-ray evidence, as well as "physical findings" and "symptomology." Dr. Simpao's supplemental statement to the District Director acknowledged that the Claimant had a significant smoking history. Nevertheless, Dr. Simpao determined that the Claimant's coal mine employment contributed to his symptoms, which he listed as shortness of breath, productive cough, and wheezing, each for 10 years or more. Dr. Baker grounded his conclusions on the Claimant's positive X-ray, history of dust exposure, and minimal smoking history. He concluded that any pulmonary impairment would be based "at least in part, if not significantly so," on the Claimant's coal mine dust exposure.

[16] Dr. Vuskovich's report is limited to the issue of disability, as reflected in medical tests. Therefore, I do not discuss his opinion in this section of my Decision.

The regulation recognizes that an individual can have clinical pneumoconiosis, notwithstanding negative X-ray evidence to that effect. See § 718.204(a)(4). As noted above, I found that the Claimant is unable to establish that he has pneumoconiosis, by means of X-ray. However, the regulation also recognizes that a physician opinion that an individual has pneumoconiosis must be based on objectively measurable data, as well as medical and work history. In the Claimant's case, he has a work history sufficient to support a finding of pneumoconiosis. However, the objectively measurable data regarding whether he has either type of pneumoconiosis is thin, at best. Dr. Simpao reported a "few crepitations" in the lungs; Dr. Baker reported a mild resting hypoxemia and wheezing. Otherwise, the physical findings on physician examination were essentially normal. Dr. Simpao also recorded that the Claimant reported shortness of breath after walking and climbing short distances. However, the record is not clear whether these data items were self-reported by the Claimant or whether Dr. Simpao actually observed the Claimant and determined that he was short of breath.

Both physicians noted that the Claimant has reported physical symptoms -- such as wheezing, coughing with sputum production, or shortness of breath -- spanning multiple years. These symptoms could be consistent with either clinical or legal pneumoconiosis. These symptoms, of course, could also be caused by the effects of cigarette smoking. In the Claimant's case, however, the evidence suggests that the Claimant's smoking habit was relatively minor. Both Dr. Simpao and Dr. Baker were aware of his long-standing smoking habit, so both likely considered it when making their assessments.

I find that both Dr. Simpao's and Dr. Baker's conclusions are based on presumptions that overstate somewhat the length of the Claimant's coal mine employment and understate somewhat the level of his smoking history. By stipulation, the Claimant has established that he has 10 years of coal mine employment, and his social security records that he has at most 11 years of such employment; however, Dr. Baker has presumed 12 years and Dr. Simpao 11 years. Both Dr. Simpao and Dr. Baker presumed that the Claimant smoked a pack of cigarettes a week for 20-25 years. However, at the hearing the Claimant testified that he smoked about 5 cigarettes a day, or "a pack a week." At the rate of 5 cigarettes a day, the Claimant would be smoking almost 2 packs per week (presuming 20 cigarettes to the pack).

I find that Dr. Simpao's report is well-reasoned regarding the issue of whether the Claimant has clinical pneumoconiosis, and I give it significant weight. Although Dr. Simpao assessed the Claimant's condition in light of what he determined to be positive X-ray evidence of pneumoconiosis, he also cited other physical signs and symptoms that he determined were supportive of the conclusion that the Claimant had pneumoconiosis. I do not find his opinions to be well-reasoned regarding the issue of legal pneumoconiosis. The regulatory definition of legal pneumoconiosis requires some type of chronic lung disease or pulmonary impairment. § 718.201(a)(2). Dr. Simpao did not discern any impairment, nor did he identify any chronic lung disease that would account for the Claimant's "symptomology."

I find Dr. Baker's determination that the Claimant has pneumoconiosis not to be well-reasoned, and I give it little weight. He cited no rationale, other than his positive X-ray finding, to support his determination that the Claimant had clinical pneumoconiosis. He diagnosed the Claimant with chronic bronchitis, by history only, which suggests that Dr. Baker observed no

physical signs compatible with that diagnosis. Although Dr. Baker's report reflects that he observed "inspiratory and expiratory wheezes," it does not make any conclusion regarding the etiology of this symptom. Nor does Dr. Baker relate this symptom to any of his diagnoses. In addition, Dr. Baker determined that the Claimant has a "Class I impairment," notwithstanding that the results of the Claimant's pulmonary function tests were within normal limits; however, he did not explain or define how he determined that the Claimant was impaired, in light of those test results. Dr. Baker also recorded that the Claimant had a mild resting hypoxemia, but he did not explain how, if at all, that finding was consistent with pneumoconiosis, or whether it could be linked to coal dust exposure.

Dr. Broudy and Dr. Repsher determined that the Claimant had neither clinical nor legal pneumoconiosis. Dr. Broudy's physical examination of the Claimant was essentially normal.[17] Although he discerned a mild resting hypoxemia, which was not disabling, he concluded that this condition was unlikely to be linked to coal mine employment, and might in fact be linked to smoking, but conceded that the results of the Claimant's carboxyhemoglobin test were equivocal regarding exposure to smoke. Similarly, Dr. Repsher's physical examination of the Claimant was essentially normal, and Dr. Repsher hypothesized that the Claimant's hypoxemia might be related to his smoking habit.

I find both Dr. Broudy and Dr. Repsher's opinions to be well-reasoned, and I give them significant weight. Both of them were unable to conclude that the Claimant had clinical pneumoconiosis, based on what they considered to be a lack of X-ray evidence, coupled with a lack of physical symptoms (other than the Claimant's mild hypoxemia). Both Dr. Broudy and Dr. Repsher found an alternative explanation for the Claimant's hypoxemia, namely his smoking history. Further, Dr. Broudy cited medical evidence that did not rule out smoking as a cause for the Claimant's hypoxemia level.[18]

In sum, then, I am left with three opinions to consider, which I must weigh. The qualifications of the physicians are relevant in assessing the respective probative values to assign to their respective opinions. Burns v. Director, OWCP, 7 B.L.R. 1-597 (1984). I note that both Dr. Repsher and Dr. Broudy are Board-certified in internal medicine and pulmonary disease. I have verified their Board certifications. See http://www.abms.org. By contrast, I have been unable to verify Dr. Simpao's Board certifications. Based on professional credentials, therefore, I give more weight to the opinions of Dr. Broudy and Dr. Repsher than I do to that of Dr. Simpao.

In addition, although all three physicians have given reasons for their conclusions, I find that Dr. Repsher and Dr. Broudy gave more complete explanations than Dr. Simpao, and both of them considered the Claimant's other medical conditions (such as his back injury and consequent

[17] Dr. Broudy's written report reflects the Claimant's weight as 219 pounds; however, at his deposition counsel asked him a question which presumed the Claimant's weight to be 292 pounds. I find no evidence of record that the Claimant ever weighed 292 pounds. Therefore, I disregarded the deposition question, and Dr. Broudy's response to it. See EX 6 at 15.

[18] Interestingly, Dr. Broudy may have considered the Claimant's coal mine employment history to be 14 years, which is significantly more than has been established. See EX 6 at 18.

pain) in their assessments. Because their reports make it evident that they have considered the Claimant's total medical history, not just his exposure to coal dust, in their assessment of his symptoms, I have more confidence in their conclusions than I do in the conclusions of Dr. Simpao, and I give their reports more weight.

Moreover, both Dr. Broudy and Dr. Repsher failed to note any lung-related abnormalities in their physical examination of the Claimant, while Dr. Simpao noted "few crepitations." Presuming pneumoconiosis to be a progressive disease, one would expect that any physical symptoms, once manifest, would remain, and might even increase. However, in the Claimant's case, Dr. Broudy and Dr. Repsher did not note any physical symptoms. Both of their examinations took place after Dr. Simpao's examination, in November 2001, and Dr. Repsher's examination occurred after Dr. Baker's September 2002 examination as well. Consequently, I conclude that any "crepitations" Dr. Simpao observed or any "wheezes" Dr. Baker observed, are not likely to be linked to pneumoconiosis, but likely have a different source.

Based on the above, therefore, I give more weight to the reports of Dr. Broudy and Dr. Repsher than I do to Dr. Simpao's report. Both of the former, Board-certified pulmonary specialists, opined that the Claimant does not have pneumoconiosis, or any other dust-related impairment. Consequently, I find that the Claimant has not established, based on physician opinion, that he has pneumoconiosis.

Weighing all the evidence presented on the issue, I find that the Claimant has not established, by a preponderance of evidence, that he has pneumoconiosis.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). In this matter, the parties have stipulated that the Claimant has 10 years of coal mine employment. Therefore, he is entitled to benefit from this rebuttable presumption.

However, as set forth above, I have found that the Claimant has not established that he has pneumoconiosis. Consequently, he is unable to benefit from this presumption.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be

considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danro Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

Pulmonary Function Tests

The record contains the following pulmonary function test results:

| Date of Test | Physician | $FEV_1$ | FVC | MVV | $FEV_1$/FVC Ratio | Valid ? |
|---|---|---|---|---|---|---|
| 11/06/2001 | Simpao | 4.66 | 5.60 | 80 | 83% | Yes |
| 02/20/2002 | Broudy | 4.17 | 5.04 | 110 | 83% | Yes |
| 09/14/2002 | Baker | 3.97 | 4.90 | unknown | 81% | Yes |
| 03/10/2004 | Repsher | 3.64 | 4.47 | 103 | 81% | Yes |

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [$FEV_1$] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the $FEV_1$ divided by the FVC that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the $FEV_1$, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The Claimant was born in March 1962, so he was 39 years old at the time of the first two tests, 40 years old at the time of the third test, and 42 years old at the time of the most recent test. The records of the Claimant's pulmonary function tests reflect that his height was measured at 71 inches (once) and 72 inches (three times). At the hearing, the Claimant testified that he is six feet, one inch tall (T. at 14). Presuming, then, that the Claimant is at least 72 inches tall, the most frequent height mentioned and the approximate median of the heights in the record, a qualifying $FEV_1$ value at age 39 is 2.56, at age 40 is 2.54, and at age 41 is 2.51.

The Claimant's pulmonary function test results do not show any qualifying values, on any pulmonary function test. Consequently, I find that the Claimant is unable to establish, by means of pulmonary function test results, that he is totally disabled.

Arterial Blood Gas Tests

The record contains the following arterial blood gas test results:

| Date of Test | Physician | $PCO_2$ | $PO_2$ | $PCO_2$ (post-exercise) | $PO_2$ (post-exercise) |
|---|---|---|---|---|---|
| 11/16/2001 | Simpao | 40.9 | 83.8 | Not done | Not done[19] |
| 02/20/2002 | Broudy | 41.6 | 72.9 | Not done | Not done |
| 09/14/2002 | Baker | 39 | 78 | Not done | Not done |
| 03/10/2004 | Repsher | 39.7 | 75.9 | Not done | Not done |

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [$PCO_2$] and percentage of oxygen [$PO_2$], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and $PCO_2$ level, a qualifying value must be less than or equivalent to the $PO_2$ listed in the table.

The test that Dr. Simpao conducted was at an altitude below 2999 feet. The altitudes at which the other arterial blood gas tests were conducted are not in the record, but I presume that they were at 5999 feet or less.[20] For $PCO_2$ values at 39 or below, the qualifying $PO_2$ value is 61 at altitudes of 2999 or less and 56 at altitudes of 3000-5999 feet. For $PCO_2$ values above 39, but below 49, the qualifying $PO_2$ value is 60 at altitudes of 2999 feet or less and 55 at altitudes of 3000-5999 feet.

The listing of arterial blood gas test results set forth above demonstrates that none of the Claimant's tests provided a qualifying value. Consequently, I find that the Claimant is unable to establish, by means of arterial blood gas test results, that he is totally disabled.

Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). As stated above, I have found that the Claimant has not established the existence of pneumoconiosis. Moreover, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

[19] The record states "no exercise arterial blood gas due to back pain" (DX 7). The regulation requires that an exercise blood gas test shall be offered unless medically contraindicated. § 718.105(b). Under the circumstances described in the record, where the Claimant had a documented history of a medical condition of a non-pulmonary nature that made exercise difficult, I find that an exercise blood gas test was contraindicated.

[20] Per 29 C.F.R. § 18.201, judicial notice may be taken of adjudicative facts. The highest point in Kentucky is 4145 feet. See: http://www.geology.com/states/Kentucky.shtml.

Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

In his initial report, dated November 2001, Dr. Simpao concluded that the Claimant had a "mild impairment." However, Dr. Simpao also concluded that the Claimant did not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment. The basis for his determination was "objective findings on the chest X-ray along with symptomology and physical findings as noted in the report" (DX 7). Dr. Simpao did not address directly the issue of the Claimant's disability in his later statement to the District Director; however, he did state that the Claimant's pulmonary conditions "have affected his ability" to perform "his last coal mining job" (DX 28 at 2).

In his report, Dr. Baker stated that the Claimant "has a Class 1 impairment with the $FEV_1$ and vital capacity greater than 80% of predicted." He also noted that the Claimant "has a second impairment with the presence of pneumoconiosis based on Section 5.8, Page 106, Guides to the Evaluation of Permanent Impairment, Fifth edition, which states that persons who develop pneumoconiosis should limit further exposure to the offending agent. This would imply the patient is 100% occupationally disabled for work in the coal mining industry or similar dusty occupation" (DX 18).

In his initial written report, Dr. Repsher did not directly address whether the Claimant was able to continue to work as a coal miner. However, Dr. Repsher did state that he found no evidence of any respiratory or pulmonary disease related to the Claimant's coal mine employment (EX 1 at 3). In his addendum, Dr. Repsher stated that "Since [the Claimant] has no pulmonary impairment, clearly from a respiratory point of view, he is fully fit to perform his usual coal mine work or work of a similarly arduous nature in a different industry" (EX 2 at 2). In his reports and his deposition, Dr. Broudy opined that the Claimant retained the capacity to continue in his occupation as an underground coal miner, or do similarly arduous manual labor (EX 3, 4; EX 6 at 17). Based on his reviews of the Claimant's pulmonary function and arterial blood gas tests, Dr. Vuskovich concluded that the Claimant had the pulmonary capacity "to continue working in the coal industry" (EX 7 at 2; EX 8 at 2).

Discussion

In this case, no physician has concluded that the Claimant is disabled from performing his last coal mine employment. Dr. Simpao has opined that the Claimant has a "mild impairment" which affects his ability to perform coal mine work. However, Dr. Simpao does not specify the manner in which the Claimant's condition affects his ability to work, nor does Dr. Simpao state that the Claimant is unable to work at all. Consequently, I find Dr. Simpao's opinion on this issue to be of little value, and therefore, I give it little weight.

Dr. Baker has opined that the Claimant is disabled from further coal mine employment, based upon his conclusion that the Claimant has pneumoconiosis. Dr. Baker's conclusion is not relevant to the issue to be decided, because it is premised on the presumption that the Claimant has pneumoconiosis, and I have already concluded that the Claimant has not established that fact. Consequently, I find Dr. Baker's opinion to be of little value. In addition, I note that, assuming arguendo that the Claimant does have pneumoconiosis, Dr. Baker's conclusion is not an opinion regarding total disability, but is merely a recommendation that he avoid future exposure to dust. Such a recommendation, the Benefits Review Board has held, is insufficient to support a finding of total disability. Jeffrey v. Mingo Logan Coal Co., B.R.B. No. 05-0107 B.L.A. (Sept. 22, 2005); see also Brumley v. Sandy Fork Mining Co., B.R.B. No. 04-0835 B.L.A. (May 23, 2005).

By contrast, Dr. Repsher, Dr. Broudy, and Dr. Vuskovich all have opined that the Claimant is not disabled from coal mine employment. They base their conclusions on the fact that the Claimant's pulmonary function tests do not establish any degree of respiratory impairment and that the Claimant's resting hypoxemia is mild, and is not qualifying by Department of Labor standards. Of these physicians, both Dr. Repsher and Dr. Broudy had information regarding the exertional requirements of the Claimant's coal mine employment: both were aware that he had operated a continuous miner and had done other jobs underground.

In order to come to a well-reasoned conclusion whether the Claimant is totally disabled, the physician must have an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Cornett v. Benham Coal, Inc., 227 F.3d 569 (6th Cir. 2000). It is not entirely clear from the record what these physicians understood about the exertional requirements of operating a continuous miner. Dr. Broudy's deposition testimony establishes that he is well experienced in assessing claimants for black lung disability benefits, seeing several claimants per week (EX 6 at 5-6). The record does not establish Dr. Repsher's experience with black lung claimant issues, and reflects that he practices in Colorado (EX 10). The record is completely silent as to what information Dr. Vuskovich had about the exertion requirements of the Claimant's coal mine employment (See EX 7 and 8). However, the record also establishes that the exertional requirements for operating a front bridge, the Claimant's most recent employment, were minimal. As the Claimant testified at his deposition, all that is required is to operate a piece of machinery (DX 15 at 7).

Based on the foregoing, I find that Dr. Broudy had a sufficient basis of knowledge of the Claimant's exertional requirements to form a well-reasoned opinion regarding whether he was disabled, and I give his opinion much weight. I give Dr. Vuskovich's opinion no weight, as there is no evidence that he had any knowledge of the Claimant's job requirements. I give some

weight to Dr. Repsher's opinion, as the record reflects that he knew what jobs the Claimant was performing, and as the record also establishes that the Claimant's last coal mine job, that of front bridge operator, required little exertion.

I find, based on the opinions presented, that the Claimant is unable to establish, by means of physician opinion, that he is totally disabled.

Weighing the evidence regarding this issue as a whole, I also find that the Claimant is unable to establish, by a preponderance of evidence, that he is totally disabled.

d. Whether the Claimant's Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. The fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. § 718.204(c)(2). A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As discussed above, I have found that the Claimant is unable to establish that he is totally disabled. Consequently, I must find that the Claimant also is unable to establish, by a preponderance of evidence, that he is totally disabled due to pneumoconiosis.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.